CASE STUDY
MARCH 2020

How the Massachusetts Health Policy Commission Is Fostering a Statewide Commitment to Contain Health Care Spending Growth

Lisa Waugh
Independent Consultant

Douglas McCarthy
Senior Research Director
The Commonwealth Fund

PROGRAM AT A GLANCE

KEY FEATURES Promotes health care cost containment by setting a statewide spending growth target and monitoring payer and provider performance against it; investigating and reporting on drivers of the total cost of care; reviewing the cost and market impact of provider combinations; providing technical support and grants to foster care delivery transformation; and making data-driven policy recommendations for health care reforms.

WHY IT'S IMPORTANT High and rising health care spending is a concern for state governments, which purchase health care and regulate health care markets. In Massachusetts, health spending has historically been higher than in other states.

BENEFITS The Health Policy Commission (HPC) has engaged diverse stakeholders in a shared cost-containment agenda. The average rate of growth in total health care spending per capita in Massachusetts has been below the HPC's benchmark from 2013 to 2018.

CHALLENGES Health insurance premiums in Massachusetts increased more than the national average from 2016 to 2018, signaling the need for additional efforts to control health care costs in the private sector.

TOPLINES

- **Health care spending growth in Massachusetts has moderated in recent years. The Health Policy Commission, established in 2012, may have played a role.**
- **Massachusetts' Health Policy Commission sets a statewide spending growth target and encourages health care organizations to do their part to control costs.**
- **Massachusetts promotes a competitive health care market by reviewing and sometimes blocking or setting conditions on mergers and acquisitions.**

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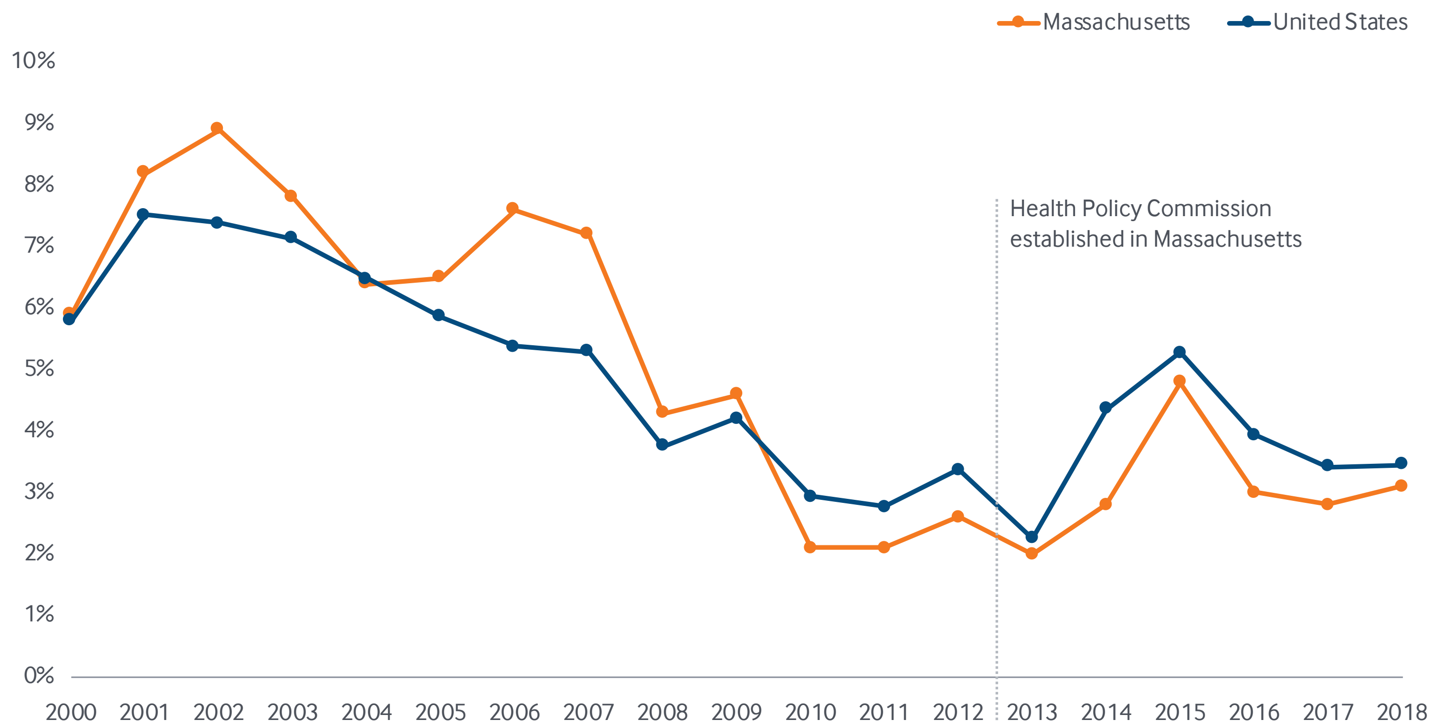
INTRODUCTION

High and rising health care spending is a concern for state governments, which purchase health care and regulate health care markets. Taxpayers stand to benefit when states reduce the growth in health care spending and free up funds to address other public priorities, such as education and transportation. State efforts to "bend the health care cost curve" also can benefit consumers by holding down premium increases and out-of-pocket expenses. This case study highlights the approach taken in Massachusetts, where health care spending has historically been higher than in other states and — until recent years — had been growing faster than the national average (Exhibit 1).

In 2012, Massachusetts established a Health Policy Commission (HPC) as an independent government agency to lead collective efforts to make health care more affordable for its residents. The HPC exercises a broad array of responsibilities. Among them are conducting and disseminating in-depth analyses about who and what is driving health care spending, making data-driven recommendations to inform public policy and opinion, and supporting regulatory action by other state agencies. According to one commentator, "the commission may encourage, cajole, and if needed, shame [health care entities] into doing their part to control costs."[1] How it does so will be described below.

Exhibit 1. Annual Growth in Total Health Care Spending per Capita: Massachusetts and the United States, 2000–2018



Notes: U.S. data includes Massachusetts. Massachusetts 2018 growth rate is preliminary.
Data: Centers for Medicare and Medicaid Services, National Health Expenditure Accounts, Personal Health Care Expenditures, 2014–2018; State Health Expenditure Accounts, 1999–2014; Massachusetts Center for Health Information and Analysis, Total Health Care Expenditures, 2014–2018; and Massachusetts Health Policy Commission, *2019 Annual Health Care Cost Trends Report* (HPC, Feb. 2020).

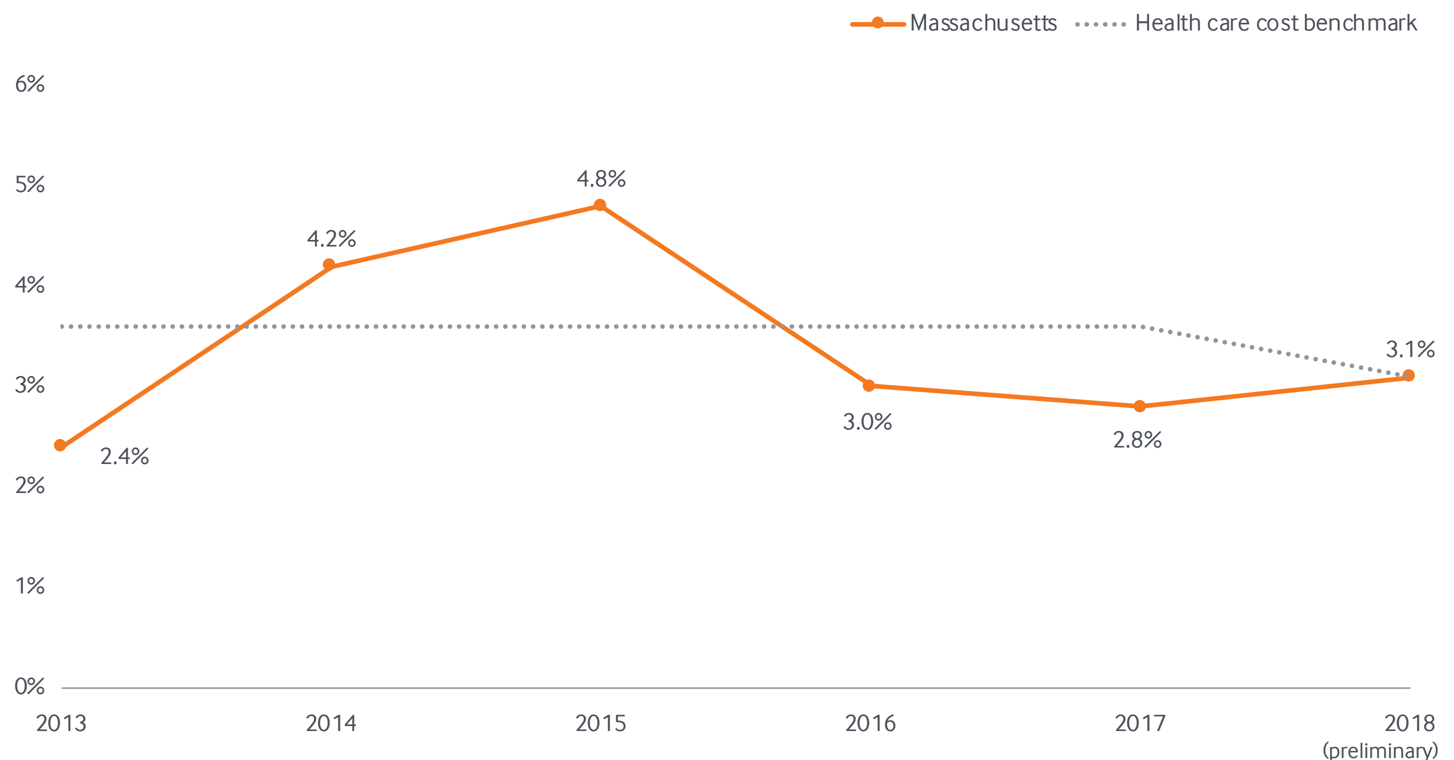
One of the HPC's best-known tools is a health care cost benchmark, which it sets according to a statutory formula (Appendix A). The benchmark represents a shared goal that total health care spending by all payers in the state will not grow faster than the state's economy. Using data supplied by a sister agency, the Center for Health Information and Analysis (CHIA; see box on page 7), the HPC monitors cost trends for the state as a whole, including spending by payer and service, as well as for specific health care entities.

From 2013 through 2017, annual growth in total health care expenditures in Massachusetts fell below the benchmark of 3.6 percent for three years and exceeded it for two years, yielding a five-year annual average of 3.4 percent (Exhibit 2).

In 2018, estimated statewide spending growth equaled a revised benchmark of 3.1 percent. In the commercial sector, slower spending growth meant that employers and consumers paid an estimated $7.2 billion less from 2013 to 2018 than they would have if the state's spending growth had matched the national average (Exhibit 3).[2]

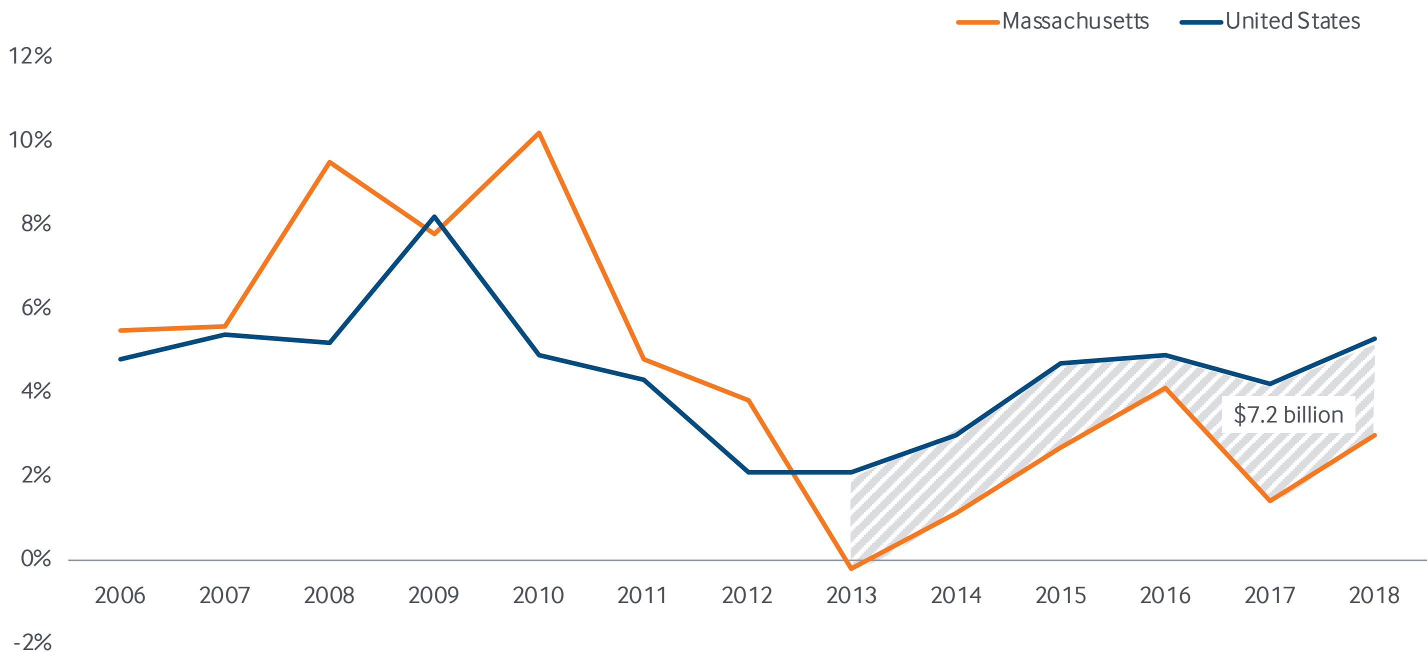
The recent slowdown in health care spending growth in Massachusetts has drawn interest and questions both from within and outside the state. Observers noted that the slowdown preceded the creation of the HPC, complicating efforts to judge its impact. Did setting a statewide spending growth target intensify the resolve of stakeholders to hold down costs? How important was the investment in credible and comprehensive cost and quality data? What role did the HPC play among other state agencies? A closer look at the HPC will help reveal what other states can learn from its experience in the context of the state's policy environment.

Exhibit 2. Annual Growth in Total Health Care Expenditures per Capita: Massachusetts Compared to Benchmark, 2013–2018



Data: Massachusetts Center for Health Information and Analysis, *Performance of the Massachusetts Health Care System: Annual Report* (CHIA, Oct. 2019).

Exhibit 3. Annual Growth in Commercial Spending: Massachusetts and the United States, 2006–2018



Notes: Data do not include insurer administrative costs. U.S. data includes Massachusetts. Massachusetts 2018 growth rate is preliminary. Center for Health Information and Analysis data are based on full-claim commercial total medical expenditures (TME).
Data: Centers for Medicare and Medicaid Services, National Health Expenditure Accounts, Personal Health Care Expenditures, 2014–2018; State Health Expenditure Accounts, 2005–2014; Massachusetts Center for Health Information and Analysis, Total Health Care Expenditures, 2014–2018; and Massachusetts Health Policy Commission, *2019 Annual Health Care Cost Trends Report* (HPC, Feb. 2020).

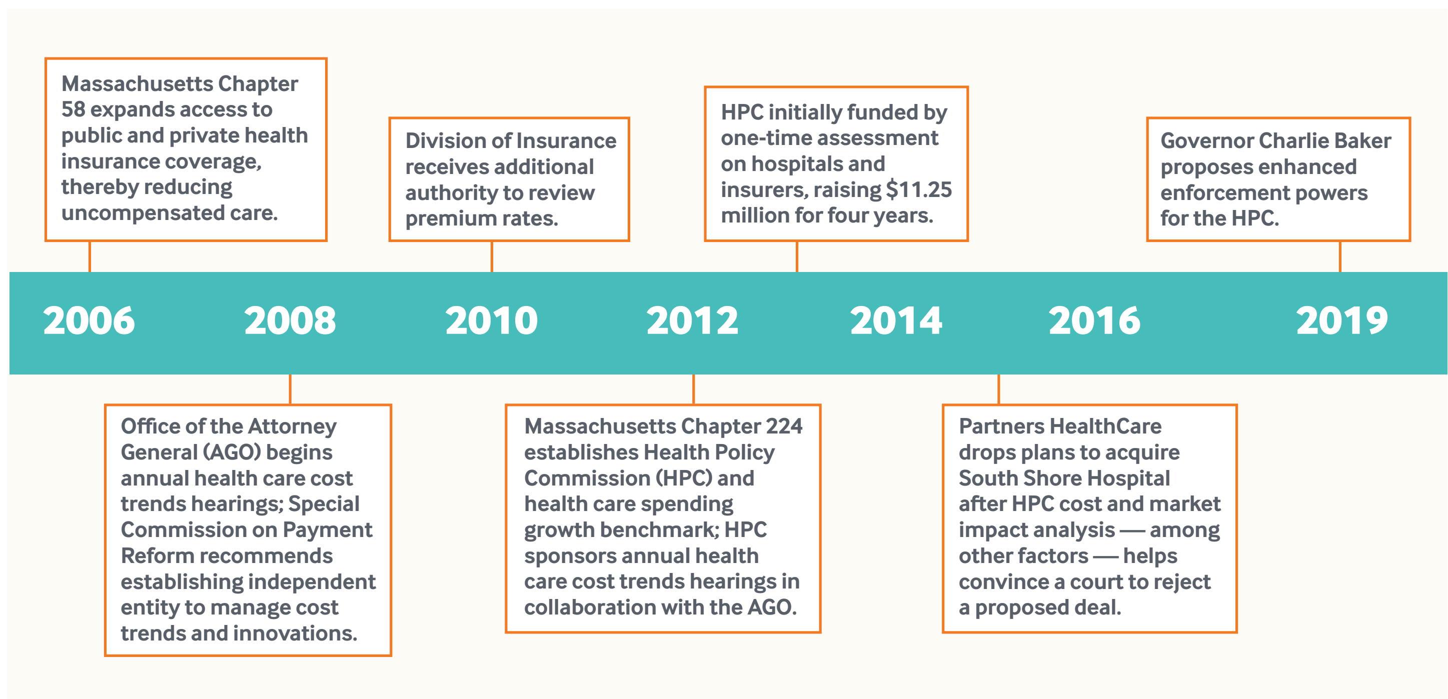
> *The goal of the HPC is to drive waste out of the health care system. And I think we've done that somewhat. We have a single-minded focus on reducing cost while improving, or certainly not harming, quality of care. We bring all of the data that we have to bear on that. Everything we're doing is focused on making the health system cheaper and better. And we will do whatever is appropriate to achieve that.*
>
> **David Cutler Ph.D.**
>
> ***HPC commissioner and Otto Eckstein Professor of Applied Economics, Harvard University***

DEVELOPMENT AND DESIGN OF THE HEALTH POLICY COMMISSION

Massachusetts has a history of stepwise reform efforts to improve the health care system through leadership from government, academic, and business sectors (Exhibit 4). Although the state experimented with regulating hospital prices during the 1980s, it abandoned the effort in the 1990s in favor of a continued reliance on market forces.[3]

In the early 2000s, a consensus emerged among political leaders that expanding coverage to the uninsured

Exhibit 4. Timeline of Health Care Reforms in Massachusetts



should take priority over addressing health care costs. In 2006, the state legislature set a goal of achieving near-universal coverage by expanding Medicaid and creating a state-based health insurance exchange.[4] (These reforms were a model for the Affordable Care Act, which the state subsequently implemented.) By 2012, 96 percent of Massachusetts residents had health coverage, making its rate of uninsured the lowest in the country.[5]

After expanding coverage and thus reducing the burden of uncompensated care, state policymakers were ready to look for other ways to control rising costs, which threatened to jeopardize the sustainability of their reforms. Between 2008 and 2010, the news media and the state attorney general conducted investigations highlighting wide variation in hospital pricing, driven by the market clout of some health systems anchored by high-profile academic medical centers and high-priced community hospitals.[6] In 2010, the state insurance commissioner disapproved health insurers' proposed double-digit premium rate increases. Although this regulatory action — the first of its kind for the state — was later overturned on appeal, it led stakeholders to recognize that a more comprehensive solution was needed.[7]

Leaders from across the policy spectrum — led by then-Governor Deval Patrick — began asking a common question: *What can we do to make the health care system more efficient and affordable?* Through a series of hearings in the state Senate, lawmakers identified a toolbox of approaches, including creating an authoritative body that would examine the issue outside the political process and engage stakeholders from the private, public, and nonprofit sectors to more aggressively address health care spending. Both for ideological and practical reasons, this solution appeared preferable to an alternative proposal to regulate health care prices.

In 2012, the legislature enacted Chapter 224 (see box on next page), which among other measures established the HPC as a permanent and independent governmental entity. The HPC was designed to provide credible policy and data analysis and to support health care cost and quality measurement, planning, and transparency in the health care system.[8] The legislature also gave the HPC a role in accelerating the adoption of alternative payment models that reward value; examining the effect of consolidation among health care providers; encouraging innovations through grants; and supporting distressed public hospitals.

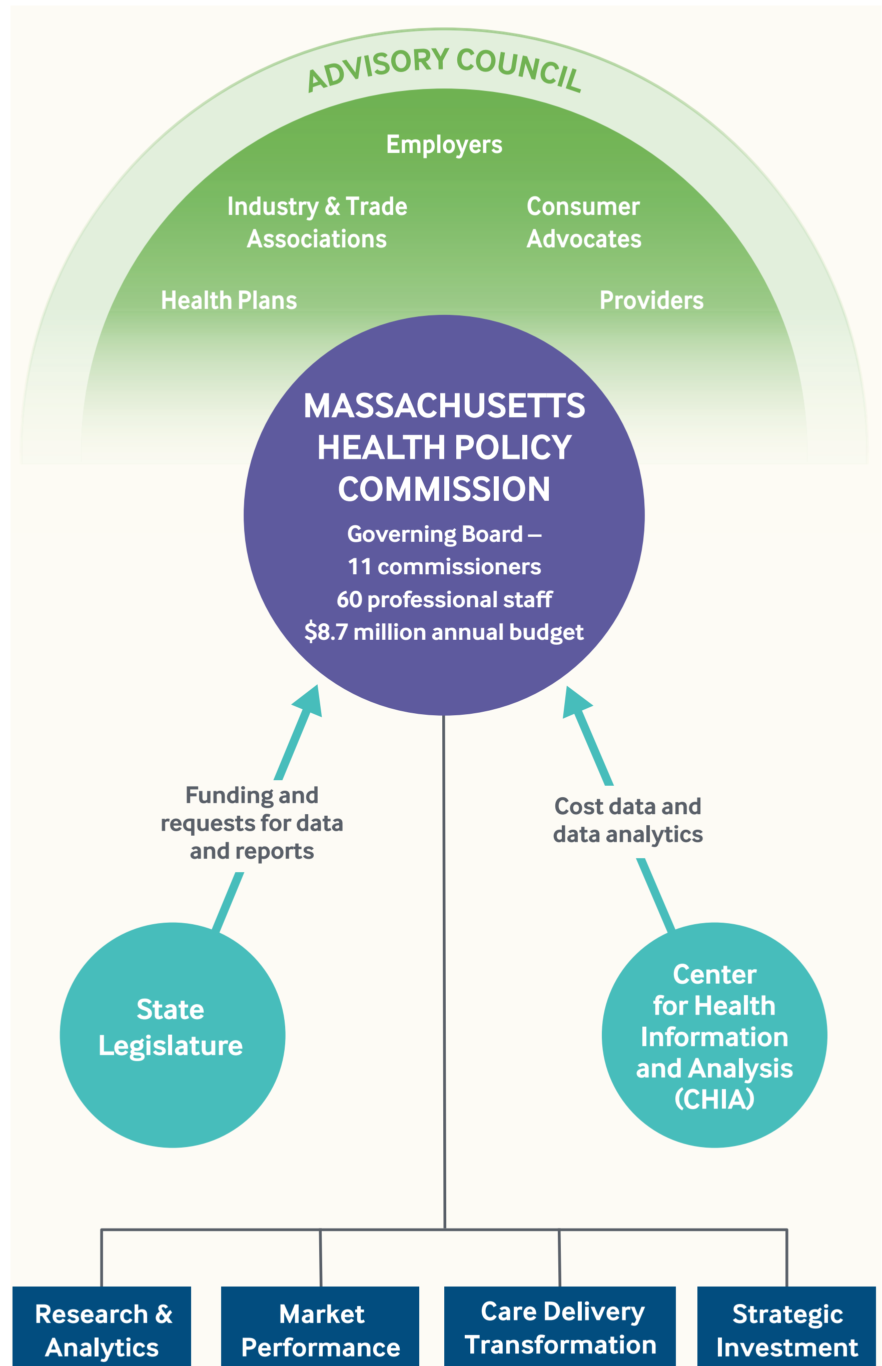
OVERVIEW OF MASSACHUSETTS STATE LAW CHAPTER 224: An Act Improving the Quality of Health Care and Reducing Costs Through Increased Transparency, Efficiency, and Innovation (2012)

- Authorized and provided funding for the Health Policy Commission (HPC) to oversee the health care market, including authority to examine provider transactions and spending, and to levy penalties of up to $500,000 for noncompliance with performance improvement plans
- Established a health care cost growth benchmark: a statewide target for the rate of growth of total health care expenditures (Appendix A)
- Established incentives for the adoption of alternative payment models in Medicaid and the private market
- Authorized the HPC to certify Medicaid accountable care organizations (ACOs)
- Enforced public reporting of provider prices and quality measures
- Required a "cooling off" period for medical malpractice actions
- Established a fund to support financially distressed hospitals
- Established a fund to support the development and expansion of electronic health records (EHRs)

STRUCTURE OF THE HEALTH POLICY COMMISSION

In collaboration with a broad group of engaged stakeholders, the HPC works with the legislature, other state agencies, and CHIA (see box on next page) to reduce the overall cost of care and improve the health care system within the state (Exhibit 5).

Exhibit 5. Overview Framework of the Health Policy Commission



CENTER FOR HEALTH INFORMATION AND ANALYSIS (CHIA)

Chapter 224 expanded the role and independent authority of this existing data collection agency, giving it the funding ($27.4 million annual budget) to invest in new capacity for developing a comprehensive data system that includes an all-payer claims database (APCD), hospital discharge data, household and employer survey data, and data-mining tools. By funding improved data collection by CHIA and enhanced analysis of these data by the HPC, the state created the capability to answer questions such as:

- *How much are we spending on health care?* CHIA collects data from insurers on the total cost of care to track overall state spending trends on a timely basis.[9]
- *Why are outpatient costs growing faster than inpatient costs?* CHIA uses insurance claims data collected in the APCD to drill down on specific cost drivers in more detail.[10]
- *How are physicians being paid?* CHIA collects data on the use of alternative payment methods (such as global and episode-based payments) to track the transition from fee-for-service to value-based care.[11]
- *Why are people picking high-deductible health plans when out-of-pocket costs could be avoided with other types of plans?* CHIA fields surveys on household insurance coverage, health care access and use, and health care affordability for Massachusetts residents, as well as on employer health insurance offerings, employee take-up rates, cost-sharing, plan characteristics, and employer decision-making.
- *What is the relationship between cost and quality of care?* CHIA supplements clinical quality data with patient experience data obtained from a survey conducted by an existing public–private partnership.
- *Where should I get care?* CHIA developed a CompareCare website that allows consumers to compare the cost of common medical procedures and the quality of care at specific facilities within the state.

While many states focus on creating APCDs, claims data alone could not address this breadth of inquiry.

Board of Commissioners

The HPC is led by an 11-member nonpartisan, independent board of commissioners, with five members (including two state cabinet officers who serve in an *ex officio* capacity) appointed by the governor and three members each appointed by the attorney general and the state auditor. Board members bring expertise and credibility to the HPC based on their reputations for health policy, economics, innovation, business, labor, and consumer advocacy. To avoid conflicts of interest, commissioners may not represent health care entities under the HPC's purview. Many consider the respect given the commission's leadership to be essential to its perceived success as an objective arbiter of cost control efforts.[12]

> “ ***The HPC introduced a culture of excellence, with a rigorous public scorecard, which is helpful when it comes to the market having to collaborate in solving this very, very challenging problem called health care.***
>
> **Jean Yang**
>
> ***Former HPC commissioner and president of public plans, Tufts Health Plan***

The HPC provides public access to board deliberations through monthly board and committee meetings, annual hearings on health care cost trends, and public "listening sessions." A multistakeholder advisory council, appointed by the HPC's executive director, offers perspectives on issues facing the Massachusetts health care market. For example, advisory council members were asked to identify their top priorities for reducing administrative complexity, which were discussed at the 2019 health care cost trends hearing.[13]

Professional Staff and Budget

The HPC is supported by a staff of 60 professionals, including data and policy analysts. Stakeholders generally expressed respect for the expertise of HPC staff and the quality of its research, the credibility of which helps to build consensus on the facts underlying potentially contentious policy issues.[14] In addition to compiling a comprehensive annual cost trends report and identifying opportunities for savings, the agency publishes focused analyses on specific topics such as:

- Variation in the performance of provider organizations
- Drug pricing practices of pharmacy benefit managers
- The impact of opioid use disorder on the health care system
- Improving the care of patients with co-occurring disorders
- Effects of "boarding" patients with behavioral health issues in emergency departments.

Funding for the HPC's annual operating budget (approximately $8.7 million in 2018) is appropriated by the legislature from assessments on acute care hospitals, ambulatory surgery centers, and payers. (See Appendix B for more information about the HPC's financing.)

FUNCTIONS OF THE HEALTH POLICY COMMISSION

The HPC is pursuing multiple approaches to help bend the health care cost growth curve and promote delivery system transformation in Massachusetts (Exhibit 6). Its authority to use these approaches reflects a legislative compromise between what policymakers considered politically feasible and what seemed likely to make a difference. It is not yet clear how much each of these tools has contributed to moderating the rate of health care spending growth.

> ***The [spending growth] target is — in and of itself — important, but I don't see it as the sole factor. I think it's also about the public platform that they have by holding hearings on all these issues. Whether it's questioning cost trends, the drivers of the trends, or strategies to bring those trends down, the HPC leverages the power of the benchmark in those hearings to promote change.***
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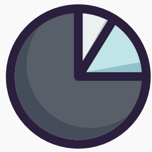
> **Audrey Shelto**
> ***President, Blue Cross Blue Shield of Massachusetts Foundation***

Exhibit 6. Policy Tools for Cost Containment

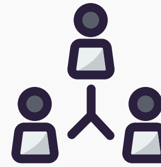


Data-Driven Policy Analysis

The HPC draws on comprehensive and credible health data resources, administered by CHIA, to investigate the drivers of growth in total cost of care.

Target Cost Growth Benchmark

Setting and monitoring the statewide health care spending growth benchmark is one of the most visible responsibilities of the HPC.



Cross-Sector Engagement

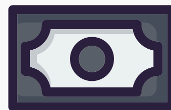
To achieve a total state health care cost growth target, the HPC engages leaders in both the public and private sectors to promote price transparency and improve efficiency.

Balancing Cost and Quality in the Value Equation

While much of its transparency efforts have focused on cost performance, the HPC has also analyzed the relationship between quality and cost and how to maintain advanced quality performance in the state.

Review of Market Performance

The HPC annually reviews the performance of individual providers and payers identified by CHIA as having excessive cost growth.



Movement to Value-Based Payment Models

The HPC monitors a statewide effort to increase the use of alternative payment models (APMs) in Medicaid and the private market, and encourages the use of APMs in its ACO certification program.

Analysis of Mergers and Acquisitions

The HPC conducts comprehensive "cost and market impact reviews" of significant health care market changes and makes recommendations to the state attorney general on health care mergers and acquisitions.

Investments in Care System Transformation

The HPC provides competitive grants to encourage the delivery of effective, efficient care and promote innovative care delivery models.

Annual Cost Trends Review Process

One of the HPC's most visible tools is an annual hearing to review health care cost trends that it conducts with the Office of the Attorney General. Both agencies have the power to compel public testimony under oath by key health care stakeholders at the hearing. A review of provider market trends and cost drivers at the 2019 hearing, for example, found that health care delivery is increasingly concentrated in the largest health systems and that higher health care spending is being driven by both higher prices and greater volume at more expensive providers.[15]

In addition, the HPC is charged with annually examining the spending performance of individual payers and providers relative to the spending growth benchmark. HPC staff examine specific health care entities referred by CHIA for having spending growth in excess of the benchmark at the business or product line level.[16] This analysis takes account of the health status of patients served by an entity and considers a range of other factors, including the entity's spending and utilization patterns and trends, population(s) served, size and market share, financial condition, prices relative to market competitors, strategies the entity has undertaken to reduce spending growth, and any factors leading to increased spending outside of the entity's control. HPC staff offer the entity an opportunity to provide confidential information and comment on its analysis.

The HPC board privately reviews cases in which a health care entity's spending growth has exceeded the benchmark. Making these initial reviews public could be problematic because much of the data relied upon may be competitively sensitive (e.g., negotiated price increases), and analyses may be hampered by small population sizes or concerns about inadequate risk adjustment, according to participants. In exceptional cases, the HPC board can require a health care entity to submit a performance improvement plan and to be subject to ongoing monitoring, with financial penalties for noncompliance, though the HPC has not yet elected to take this step.

An unresolved policy challenge is whether and how to weigh different starting points when assessing entities' spending growth against the benchmark. For example, does an entity with dominant market share and relatively high prices merit greater scrutiny than a lower-cost competitor with similar spending growth?

The HPC's cost trends review process appears to be having a "sentinel effect" that helps to restrain market behavior, perhaps because entities wish to avoid public shaming that could result from being questioned in a public hearing or from being required to submit a performance improvement plan. Some stakeholders said that the HPC's review of health care entities' spending growth — in combination with the agency's public scrutiny of cost trends and drivers in relation to the benchmark — aids insurers in holding the line in price negotiations with health care providers. However, one industry leader said the HPC's influence has been overstated in this regard.

Other Policy Tools

In addition to its role in the annual benchmarking process, the HPC collects detailed data on the structure of the health care provider market, monitors new provider affiliations including mergers and acquisitions, and conducts comprehensive "cost and market impact reviews" of any change in the provider market that could have a significant impact on health care costs or market functioning. The HPC also certifies accountable care organizations (ACOs), which is required for participation in the state's Medicaid program, and provides technical support and targeted investments to support health care delivery reform efforts in the state. Stakeholders generally said the HPC's reviews of mergers and acquisitions were influential, but they were uncertain about the impact of its efforts to encourage alternative payment models.

> *Massachusetts has had a long history of really serious concern about its health care system and a willingness on the part of state government to do something about it. To other states, the most important thing I can say is this: as a first step, it's very important to develop a data system that captures price information. As a second step, it's essential to require providers, payers, and various actors to share detailed cost, quality, and utilization information — not only for Medicaid but across the public and private sectors.*
>
> **Stuart Altman**
>
> *Chair, HPC Board of Commissioners, and Sol C. Chaikin Professor of National Health Policy, Heller School for Social Policy and Management, Brandeis University*

Complementary Roles of Other State Agencies and Officials

While the HPC is often given credit for driving the cost containment agenda in Massachusetts, it does not work on its own. Informed by health data from CHIA, other agencies and officials play unique and complementary roles in making legal and regulatory decisions that may help hold down health care spending growth. These include the Office of the Attorney General (see box below), the Division of Insurance, and components of the Executive Office of Health and Human Services, including the Department of Public Health and the state Medicaid program, known as MassHealth.

Other state agencies benefit from the HPC's oversight of the statewide spending growth benchmark and from the informed public discussion that it generates. For example, the benchmark guides MassHealth in setting Medicaid payment rates, and it provides a broader context for premium rate reviews by the Division of Insurance. In similar fashion, the HPC's cost and market impact reviews create an environment in which the state attorney general has pursued more aggressive and wide-ranging settlements with health care providers seeking to combine through mergers, acquisitions, or affiliations.

SYNERGISTIC ROLES OF THE HPC AND THE OFFICE OF THE ATTORNEY GENERAL

Massachusetts has given its Office of the Attorney General (AGO) enhanced powers to investigate the drivers of health care costs, which augments its role in consumer protection and antitrust enforcement. Using its authority to subpoena health care entities to obtain pricing information, the AGO conducted cost analyses that were instrumental in the policy discussion leading to enactment of Chapter 224 and the creation of the HPC. The AGO continues to use this authority to help inform the HPC's annual cost trends hearing.

The AGO also conducts law enforcement investigations of proposed mergers and acquisitions between health care entities and may pursue litigation to block a transaction that would substantially limit market competition. Separately, the HPC conducts cost and market impact reviews of the effect of proposed market transactions on cost, quality, and access to care in the state. The AGO may consider the HPC's findings in its antitrust review.

In an early case that defined its role, the HPC submitted comments on a proposed settlement negotiated between former state Attorney General Martha Coakley and Partners HealthCare, the state's largest health care system, that would have allowed Partners to acquire South Shore Hospital and two suburban hospitals under specific conditions.[17] Based on its analysis, the HPC argued that the transaction would increase costs for consumers.[18] Newly elected Attorney General Maura Healey objected to the settlement, saying, "I would prefer to reverse the order of events and instead consider any future proposed Partners' expansion only after Partners demonstrates an ability to contribute to health care cost containment in Massachusetts."[19] The court subsequently rejected the agreement, leading Partners and South Shore to abandon the acquisition attempt.[20]

In another recent case, the HPC's analysis raised concerns about the impact of a proposed merger between Beth Israel Deaconess Medical Center, Lahey Health, and three other hospital organizations.[21] Based in part on the HPC analysis and on its own antitrust review, the AGO negotiated conditions for the proposed merger, such as requiring the combined organization to abide by a seven-year price cap and maintain financial commitments to support health care services for low-income and underserved communities statewide.[22]

LESSONS AND INSIGHTS FOR OTHER STATES

The following insights from Massachusetts' experience with the HPC can be adapted by other states to fit their unique history, policy needs, and political and market context.

Focus on total spending growth as well as its components. Many state governments focus primarily on cost control in Medicaid, which makes up a large share of state budgets. However, the economic impact of increasing health care prices on insurance premiums and patient cost-sharing is also a growing concern for states. The interrelated nature of the health care system means the ability to reduce spending growth is likely to be limited without a comprehensive approach. Focusing on total (all-payer) state health care spending growth can help engage leaders in both the public and private sectors in complementary efforts to reduce costs. It's also important to assess how each sector and category of spending (whether inpatient, outpatient, or pharmacy) contributes to overall spending growth and to devise appropriate cost-control strategies for each. Placing such efforts in the context of a total spending growth benchmark encourages a whole-system perspective to help avoid cost-shifting from one part of the system to another, said David Seltz, the HPC's executive director.

> ***For most states, it's a matter of how urgent the situation is. In the early 2010 timeframe, Massachusetts was experiencing some of the highest premium spikes in the country, so we needed to get serious. But it's important to do so in a reasonable way through an institutional structure similar to the HPC. If you're in a state that's just beginning this journey, you could design a commission structure that is given a different type of, or a different level of, authority.***
>
> **Michael Caljouw**
>
> ***Vice president, State Government and Regulatory Affairs, Blue Cross Blue Shield of Massachusetts***

Set a reasonable spending growth target. Setting and monitoring a health care spending growth target can help pull stakeholders toward a common goal for improvement. While the methodology used to set the benchmark needs to be credible, some stakeholders cautioned that "the perfect should not become the enemy of the good" in devising a reasonable target. Other states, including Colorado, Delaware, Maryland, Oregon, Rhode Island, and Vermont, have developed their own approaches for measuring and benchmarking total costs in the health care system.[23] (See Appendix A for details of how the benchmark is calculated in Massachusetts.)

Consider how other policy goals intersect with a spending growth target. Some observers expressed concern that a total spending growth target may limit efforts to increase resources in areas that have been underfunded in the past, such as primary care and behavioral health care.[24] However, others believe it is the job of stakeholders to balance competing priorities within the global budget limits implied by the spending benchmark. To rebalance health care spending priorities, Gov. Charlie Baker has proposed requiring health care entities to increase their spending on primary care and behavioral health care by 30 percent from current levels over three years while keeping overall spending growth under the benchmark.[25]

Build a data-driven process to track progress toward cost containment goals. Massachusetts invested in developing a credible data collection and reporting system administered by CHIA (see box on page 7) to determine the drivers of cost growth and monitor cost trends. This is a logical first step for other states pursuing a cost containment agenda. Because health insurance claims data are limited in scope and can have a significant time lag, Massachusetts supplements its all-payer claims database (APCD) with more timely reporting on total cost trends by insurers.[26] Massachusetts also created a mechanism for collecting structural information about health care provider organizations to attribute individual provider performance to systems of care.[27]

States that have already established an APCD might consider expanding their data collection in a similar fashion to promote timely tracking of cost trends. States without APCDs might consider starting with aggregate reporting of cost trends by insurers while they build a more robust health data capability. Massachusetts' experience also suggests the importance of cultivating trust by seeking input from the private sector on cost calculation methodologies used in public reporting.

Seek value by balancing cost and quality of care. Massachusetts has been a leader in measuring and publicly reporting on quality of care through public–private efforts that predate the creation of the HPC.[28] The HPC contributes to the work of a multistakeholder Statewide Quality Advisory Committee, chaired by CHIA's executive director, that recommends a set of standard measures for use by state agencies and health plans to assess the quality of care. While the HPC seeks to promote care delivery transformation and quality improvement, many of its efforts have focused on costs of care and ensuring that — at the very least — quality of care is not compromised by cost control. States that lack a history of quality measurement and reporting may wish to give greater priority to these topics.

Design a commission with appropriate scope and authority. To create oversight for health care cost and quality, states are using a variety of approaches, some of which draw from or bear similarities to the Massachusetts model.[29] The Massachusetts legislature continues to expand the responsibilities of the HPC, which can be seen as a vote of confidence in its abilities but may detract from its core mission. While many stakeholders expressed confidence in the value of the HPC to the state, some say it has become a larger bureaucracy than they originally envisioned. Stakeholders noted that administrative costs might be reduced if the functions of the HPC and CHIA were combined into a single entity.

Consider how to engage with and represent stakeholders. Leadership of a commission like the HPC can be designed in a variety of ways. The HPC board appointment process is intended to avoid overt political influence and business conflicts of interest. Most stakeholders cited this as a strength that ensures the HPC's objectivity and credibility. Some stakeholders expressed concern that the HPC board lacks industry expertise and diversity, a criticism that the HPC Advisory Council was intended to address. Other states may wish to consider how to ensure that the makeup of such a body reflects the diversity of the state's population, including the perspective of patients and their families.

IMPLICATIONS AND CONCLUSION

It has taken Massachusetts significant time and resources to establish a credible, data-driven statewide effort to address health care costs. The Health Policy Commission has played a central role in coordinating a cross-sectoral effort to build a more efficient health care system in the state. All stakeholders appear to agree that the HPC has raised the level of the policy debate. The HPC's work has educated the public, providers, plans, employers, and patient advocates on the common facts of health care cost growth in the state, resulting in more informed advocacy and policymaking. This accomplishment alone may be of interest to other states.

While it is plausible that the HPC's role and activities have helped foster the slower growth in health care spending in Massachusetts, skeptics point out that the trend does not constitute causal proof of effectiveness.[30] Despite lower-than-average overall spending growth, Massachusetts employers' health insurance premiums increased more than the national average from 2016 to 2018.[31] Some say

the spending benchmark is largely aspirational and that the HPC is working around the margins of cost issues. They are concerned that without the power to set and enforce a more aggressive benchmark or impose price controls, real change will remain elusive. However, many see price controls as a last resort — a strategy that could undermine public–private collaboration, which appears to be working.[32]

It is too soon to know whether the recent uptick in health care spending in Massachusetts since 2017 (see Exhibit 1) portends a sustained upward trend. The HPC's mettle has yet to be fully tested under conditions in which health care spending growth — for the state or specific entities — substantially and persistently exceeds the benchmark. Perhaps in anticipation of such an event, Gov. Baker recently proposed enhancing the HPC's power to levy penalties on insurers and providers that fail to meet the benchmark, without first requiring them to submit a performance improvement plan.[33]

Looking ahead, the HPC has identified several priority issues for cost containment in Massachusetts (see box at right).[34] Several of the governor's recent legislative proposals are consistent with the HPC's recommendations on issues like enhancing consumer protections for surprise out-of-network bills, advancing the appropriate use of telemedicine, and moderating prescription drug spending growth. These and other issues will be key challenges for the HPC and its constituencies, and will bear watching by other states considering how to achieve high-quality, affordable health care.

PRIORITY ISSUES FOR HEALTH CARE COST CONTAINMENT IN MASSACHUSETTS

- Focusing on administrative waste and reducing duplicate reporting and unnecessary paperwork that burden the system
- Addressing the high cost of prescription drugs, which will test the ability of the HPC to engage a pharmaceutical industry that is primarily regulated at the federal level (the governor has proposed that manufacturers of new, high-cost drugs be subject to the HPC's accountability process)
- Tackling the rising cost of employer-sponsored health insurance premiums, which have surpassed the spending growth benchmark
- Assessing the impact of deductibles, copayments, coinsurance, and other out-of-pocket expenses, which rose 5.7 percent because of an increasing number of high-deductible health plans
- Exploring and addressing the spending growth in hospital outpatient services, which also grew faster than the benchmark

Data: Massachusetts Health Policy Commission, *2018 Annual Health Care Cost Trends Report* (HPC, Feb. 2019).

> *The value of the commission is that they have surfaced important issues that are impacting the value of care within the Commonwealth. A great example is pharmaceutical costs, which are a major driver of expense here in the Commonwealth. I think the fact that we brought that issue up, that we got different stakeholders to discuss it, was very useful . . . because it was an awareness intervention.*
>
> **Gregg S. Meyer, M.D., M.Sc.**
> *Chief clinical officer, Partners HealthCare*

HOW WE CONDUCTED THIS CASE STUDY

This case study is based on in-depth interviews with stakeholders who have worked with and witnessed the design, development, and influence of the Health Policy Commission (HPC) in Massachusetts. Semistructured interviews were conducted with more than 40 key informants including commissioners and staff of the HPC; members of the HPC Advisory Council representing health care providers, payers, purchasers, and advocates; the staff of Commonwealth of Massachusetts agencies and officials including the Center for Health Information and Analysis, Office of the Attorney General, and Executive Office of Health and Human Services; current and former state legislators; and other engaged stakeholders and observers. Content analysis revealed key issues, commonalities, and differences of opinion and perspective. Findings were placed in the context of the literature on the history of Massachusetts reform efforts.

NOTES

1. Robert Steinbrook, "Controlling Health Care Costs in Massachusetts with a Global Spending Target," *JAMA* 308, no. 12 (Sept. 26, 2012): 1215–16.

2. Massachusetts Health Policy Commission, *2019 Annual Health Care Cost Trends Report* (HPC, Feb. 2020).

3. John E. McDonough, "Tracking the Demise of State Hospital Rate Setting," *Health Affairs* 16, no. 1 (Jan./Feb. 1997): 142–49.

4. The 191st General Court of the Commonwealth of Massachusetts, *Chapter 58: An Act Providing Access to Affordable, Quality, Accountable Health Care* (Apr. 2006).

5. Henry J. Kaiser Family Foundation, "Health Insurance Coverage of the Total Population: 2017" (Kaiser Family Foundation, n.d.).

6. Liz Kowalczyk and Scott Allen, "AG Finds Clout of Hospitals Drives Cost: State's Insurers Pay Twice as Much to Some Providers," *Boston Globe*, Jan. 29, 2010.

7. Barbara Anthony, Celia Segel, and Hallie Toher, "Beyond Obamacare: Lessons from Massachusetts," *Journal of Health & Biomedical Law* 14, no. 2 (Nov. 2018): 285–347.

8. Robert E. Mechanic, Stuart H. Altman, and John E. McDonough, "The New Era of Payment Reform, Spending Targets, and Cost Containment in Massachusetts: Early Lessons for the Nation," *Health Affairs* 31, no. 10 (Oct. 2012): 2334–42.

9. Center for Health Information and Analysis, *Methodology Paper: Total Medical Expenses* (CHIA, Aug. 2015).

10. The Supreme Court ruled, in the case of *Gobeille v. Liberty Mutual Insurance Co.*, that states cannot require self-insured employee health benefit plans governed by the federal Employee Retirement Income Security Act (ERISA) to submit data to state all-payer claims databases. States may request that self-insured ERISA plans submit data on a voluntary basis, typically through third-party administrators (TPAs). According to sources, there is a relatively high level of voluntary reporting in Massachusetts in part because the market is primarily served by a few large state-based health insurers that often serve as TPAs for the state's self-insured employers.

11. Center for Health Information and Analysis, *Payer Data Reporting: Total Medical Expenses (TME) and Alternative Payment Methods (APM)* (CHIA, Mar. 2015).

12. Since its inception, the Health Policy Commission has been chaired by Stuart Altman, the Sol C. Chaikin Professor of National Health Policy at the Heller School for Social Policy and Management at Brandeis University. Altman is an economist with five decades of experience in federal and state health policy within government, the private sector, and academia. See Bruce Mohl, "Stuart Altman: Health Care Watchdog," *CommonWealth Magazine*, Jan. 12, 2016.

13. Massachusetts Health Policy Commission, "2019 Health Care Cost Trends Hearing, Day One," presentation, HPC, Oct. 22, 2019.

14. The Health Policy Commission's executive director, David Seltz, has led the agency since it was created. He was formerly the health policy advisor to Gov. Deval Patrick and chief of staff to the state Senate president. In those roles, he was involved in developing key health policy legislation during the last decade, including Chapter 224.

15. Massachusetts Health Policy Commission, "2019 Health Care Cost Trends Hearing, Day Two," presentation, HPC, Oct. 23, 2019.

16. The Center for Health Information and Analysis examines "managing physician group total medical expenses," which is a measure of the total health care spending of members whose plans require the selection of a primary care provider associated with a physician group, or who are attributed to a primary care provider pursuant to a contract between a payer and provider, adjusted for health status. When such an entity is referred to the HPC for exceeding the benchmark, the HPC examines its circumstances broadly in the context of its organizational affiliations with health care facilities, payers, and specialists (personal communication with HPC staff, Jan. 9, 2020).

17. Massachusetts Health Policy Commission, Letter to the Honorable Janet L. Sanders, "RE: *Commonwealth of Massachusetts v. Partners HealthCare System, Inc., South Shore Health and Educational Corp., and Hallmark Health Corp.,* Superior Court Civil Action No. 14-2033-BLS," July 17, 2014; and Massachusetts Health Policy Commission, Letter to the Honorable Janet L. Sanders, "RE: *Commonwealth of Massachusetts v. Partners HealthCare System, Inc., South Shore Health and Educational Corp., and Hallmark Health Corp.,* Superior Court Civil Action No. 14-2033-BLS," Oct. 21, 2014.

18. Julie M. Donnelly, "Partners HealthCare Fails to Sway Regulators on South Shore Deal," *Boston Business Journal*, Feb. 19, 2014.

19. Martha Bebinger, "AG Healey Weighs in Against Partners Acquisition of South Shore Hospital," *CommonHealth,* WBUR 90.9, Jan. 26, 2015.

20. Lisa Schencker, "Partners HealthCare Drops Plans to Acquire South Shore," *Modern Healthcare*, Feb. 18, 2015.

21. Paige Minemyer, "Watchdog Group Asks Massachusetts AG to Review Beth Israel-Lahey Merger," *Fierce Healthcare*, Sept. 28, 2018.

22. Office of Attorney General Maura Healey, "AG Healey Reaches Settlement with Beth Israel, Lahey Health over Proposed Merger," press release, Nov. 29, 2018.

23. Rachel Block, *State Models for Health Care Cost Measurement: A Policy and Operational Framework* (Milbank Memorial Fund, Apr. 2015); and Joel S. Ario, Kevin Casey McAvey, and Kyla M. Ellis, *Implementing a Statewide Healthcare Cost Benchmark: How Oregon and Other States Can Build on the Massachusetts Model* (Manatt Health, Dec. 2019).

24. Massachusetts spends less than the national average on primary care as a share of total health care spending; see HPC, "2019 Hearing, Day Two," 2019.

25. Office of Gov. Charlie Baker and Lt. Gov. Karyn Polito, "Baker–Polito Administration Announces Health Care Legislation Aimed at Addressing Key Challenges," press release, Oct. 18, 2019.

26. CHIA, *Payer Data Reporting,* 2015.

27. Commonwealth of Massachusetts, Massachusetts Registration of Provider Organizations (MA-RPO) Program home page, n.d.; and Kara Vidal et al., "When an APCD Is Not Enough (You Need RPO): Developing a System to Map the Structures and Relationships of Massachusetts' Largest Healthcare Providers," poster presentation, 2016 AcademyHealth Annual Research Meeting, Boston, June 2016.

28. Massachusetts Health Quality Partners has convened stakeholders in collaborative performance measurement and public reporting activities since 1995; see Jeffrey Levin-Scherz and Thomas H. Lee, "A Collaborative Model for Public Reporting on Provider Effectiveness and Patient Experiences — Massachusetts Health Quality Partners" (Commonwealth Fund, n.d.).

29. Sunita Krishnan, *Health System Oversight by States: An Environmental Scan* (Altarum Healthcare Value Hub, Nov. 2017); Lesa Rair and Sarabeth Zemel, *Addressing and Reducing Health Care Costs in States: Global Budgeting Initiatives in Maryland, Massachusetts, and Vermont* (National Academy for State Health Policy, Jan. 2016).

30. Stephen Soumerai, Ross Koppel, and Marina Bolotnikova, "Lessons from Massachusetts' Failed Healthcare Cost Experiment," *The Health Care Blog*, Sept. 27, 2017.

31. Sara R. Collins, David C. Radley, and Jesse C. Baumgartner, *Trends in Employer Health Care Coverage, 2008–2018: Higher Costs for Workers and Their Families* (Commonwealth Fund, Nov. 2019).

32. For example, the HPC staff are supporting a public–private collaborative effort to understand the causes of and reduce the frequent use of the emergency department; see the Massachusetts Employer Health Coalition home page.

33. Office of Baker and Polito, "Administration Announces Health Care Legislation," 2019.

34. Massachusetts Health Policy Commission, *2018 Annual Health Care Cost Trends Report* (HPC, Feb. 2019).

35. Massachusetts Health Policy Commission, Health Care Cost Growth Benchmark (HPC, Mar. 2017).

APPENDIX A. CALCULATING THE STATEWIDE HEALTH CARE SPENDING GROWTH BENCHMARK

The health care cost benchmark is a statewide target for the rate of growth of total health care expenditures (THCE). THCE is a per capita measure of total state health care spending growth, which includes: 1) medical expenses paid to providers by private and public payers, including Medicare and Medicaid (MassHealth); 2) patient cost-sharing amounts; and 3) the total net cost of private insurance. THCE is calculated on a per capita basis to control for increases in health care spending resulting from population growth.

Chapter 224 established that from 2013 to 2017, the benchmark for the rate of growth of THCE would be equivalent to the projected growth in the annual gross state product (GSP) as a measure of the state's economic growth rate. Based on this statutory formula, the HPC set the benchmark at 3.6 percent from 2013 to 2017. To help reduce the state's historically high cost of care, Chapter 224 requires that the benchmark be ratcheted down by 0.5 percent less than GSP from 2018 to 2022, unless the HPC determines that an adjustment is warranted. The HPC concurred in the reduction and set the benchmark growth rate at 3.1 percent for 2018, 2019, and 2020.[35] Given the shift in health care spending nationally, Stuart H. Altman, the HPC board chair, noted that, "it may be time to consider whether additional flexibility is warranted for the HPC to set the benchmark lower than 3.1 percent."

APPENDIX B. FINANCING THE HEALTH POLICY COMMISSION

From 2013 to 2016, the HPC was solely funded by two trust funds: the Health Care Payment Reform Trust Fund and the Distressed Hospital Trust Fund, both of which were funded through a one-time assessment on certain large health care provider systems. In fiscal year 2017, the HPC moved onto the state budget with operating expenses supported by a line-item appropriation that is fully assessed on certain large health care providers and payers. The language in the enabling statute is an assessment of no less than 33 percent from health plans, no less than 33 percent from hospitals and ambulatory surgery centers, and up to 33 percent from the state's general budget. Through regulation, the HPC subsequently set these assessment amounts at 50 percent for eligible providers and 50 percent for payers. The legislature is reportedly considering new ways of providing financial support, possibly by expanding the assessors to include other industry participants (e.g., pharmaceutical industry, independent urgent care centers).

ABOUT THE AUTHORS

Lisa Waugh, Ph.D., is an independent consultant with an extensive background in domestic and global health policy and evaluation research. She has worked with the Clinton Health Access Initiative and the Colorado Department of Health Care Policy and Financing. Most recently she served as a program director at the National Conference of State Legislatures. Past consulting projects have been funded by the Gates Foundation, the Lucille Packard Foundation for Children's Health, Abt Associates, and the U.S. Agency for International Development (USAID).

Douglas McCarthy, M.B.A., is senior research director for the Commonwealth Fund and president of Issues Research, Inc., in Durango, Colorado. He has supported the Commonwealth Fund's work on a high-performance health system since 2002 through the development of chartbooks and scorecards on health system performance and case study research on promising practices and innovations in health care delivery. Mr. McCarthy's 30-year career has spanned roles in government, corporate, and nonprofit organizations, including the Institute for Healthcare Improvement and UnitedHealth Group's Center for Health Care Policy and Evaluation. He was a public policy fellow at the University of Minnesota's Humphrey School of Public Affairs and a leadership fellow of the Denver-based Regional Institute for Health and Environmental Leadership. Mr. McCarthy serves on the boards of Colorado's Center for Improving Value in Health Care and the Peak Health Alliance.

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For more information about this case study, please contact:

Douglas McCarthy
Senior Research Director
The Commonwealth Fund
dm@cmwf.org

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